Meeting Minutes
Health Information Technology Council Meeting

February 3, 2014
3:30 – 5:00 P.M.

One Ashburton Place, 21th floor Matta Conference Room
Boston, MA

Meeting Attendees

Name	Organization	Attended
John Polanowicz	*(Chair) Secretary of the Executive Office of Health and Human Services*	No
Manu Tandon	*(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
William Oates	*Chief Information Officer, Commonwealth of Massachusetts*	Yes
David Seltz	*Executive Director of Health Policy Commission*	No
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	No
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	No
Patricia Hopkins MD	*Rheumatology & Internal Medicine Doctor (Private Practice)*	Yes
Meg Aranow	*Senior Research Director, The Advisory Board Company*	Yes
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	Yes
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	No
Jay Breines	*Executive Director, Holyoke Health Center*	No
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	No
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	No
Margie Sipe, RN	*Performance Improvement Consultant, Massachusetts Hospital Association (MHA)*	Yes
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	Yes
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	No
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Yes
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, Southeast Massachusetts Council on Addiction (SEMCOA)*	Phone
Kristin Thorn (acting)	*Director of Medicaid*	No

Guest

Name	Organization
Robert McDevitt	EOHHS
Nick Welch	EOHHS
Claudia Boldman	ITD
Sean Kennedy	MeHI
Jennifer Monahan	MAeHC

Name	Organization
Micky Tripathi	MAeHC
Mark Belanger	MAeHC
Kathleen Snyder	EOHHS
Amy Caron	EOHHS
Darrel Harmer	EOHHS
Pam May	Partners Health Care
Jessica Costantino	AARP
Nelson Gagnon	Orion
Susan Fendell	Mental Health Legal advisors
Jacob Buckley – Fortin	EHana LLC
Adrian Gropper	PPR / MMS
Lisa Fenichel	Consumer Healthcare / Advocate

Meeting called to order – minutes approved

The meeting was called to order by Manu Tandon at 3:32 P.M.

The Council reviewed minutes of the January 13, 2014 Health Information Technology Council meeting. The minutes were approved as written.

The Board welcomed Bill Oats, Chief Information Officer for the Commonwealth of Massachusetts (replacing John Letchford), and Daryl Harmer, the new assistant Chief Information Officer for the Health Information Exchange at The Executive Office of Health and Human Services (EOHHS).

Special thanks were given to Laurance Stuntz and Sean Kennedy for the great work the Massachusetts eHealth Institute (MeHI) has done to get organizations signed up and in the HIway connection pipeline. The Office of the National Coordinator (ONC) grant that is funding the Last Mile Program to help connect organizations to the HIway will end on Friday, February 7th - the Council looks forward to hearing updates from the Massachusetts eHealth Institute in the future.

Discussion Item 1: Mass HIway Update (Slides 3-8)

See slides 3-18 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Implementation and Support Update presented by Manu Tandon, Executive Office of Health and Human Services (EOHHS) Secretariat Chief Information Officer and Massachusetts Health IT Coordinator.

(Slide-4) Outreach & Communications Update - With the ONC grant that is funding MeHI's Last Mile Program ending on Friday, the biggest priority is to ensure the people in the pipeline continue to move

along. There is a knowledge transfer that needs to happen. Next steps are to create a plan for the future, and document what is needed in terms of resources. EOHHS will continue to focus on anyone in the pipeline, as well as the four Phase 2 pilot entities.

(Slide 5) HIway Operations Update - 12 new participation agreements were completed in January- there are currently 128 HIway participant organizations signed up. The Phase 2 service addendum was executed with the four participants from the January Phase 2 event.

(Slide 6) HIway Operations Update - January was the biggest connection month so far with 39 organizations going live. A large driver was the Implementation grants expiring, as well as the Meaningful Use requirements. There are now 99 total live HIway connections.

(Slide 7) HIway Operations Update - As requested at the last meeting, the Council was provided with a 13 month view of transaction activity. January saw a slight dip in the number of transactions- 106,000. The spike in April and May is due to testing.

- Question (Laurance Stuntz): Is there a way to pull those [test transactions] out?
    - Answer (Manu Tandon): Yes, but not without a lot of manual work - they went through our production environment so they were counted.

(Slide 8) HISP to HISP Connectivity- Surescripts testing is complete, they are ready to take the technology and release it into production. Dimock sent a test transaction to the HIway via eClinicalWorks and the team continues to work with Secure Exchange Solutions to address any issues. A list of vendors on the docket for February/March was provided.

EOHHS will continue to work on the transition of the outreach program and the Health Information Service Provider (HISP) agreements. The updated rate card will be presented at the next meeting as well as some milestones in terms of what functionality will be rolled out in 2014.

- Question (Meg Aranow): Do you know what the use cases are for EasCare [Ambulance Service]?
    - Answer (Sean Kennedy): EasCare is one of the grantees, they are working with Boston Healthcare for the Homeless and they are working to cut down costs. They have a system of paper charts right now, everything is hand written. Looking to have more efficient transfer of information.
- Comment (John Halamka): MedFlight has also asked for this. There is value for them- if you are picked up in an ambulance and you have a serious allergy, the HIway would facilitate getting that information to the first responder.
- Comment (Manu Tandon): There are really no standards in that area right now.
- Comment (John Halamka): Currently there is a lot of paper in first responder organizations, but they are starting to look at iPads- things that are very proprietary and Electronic Health Record-lite to help record those first responder events.
- Comment (Laurance Stuntz): Fallon had said part of the reason they were interested in doing this was to get a leg up on contracts with the Accountable Care Organizations. They can say to

Atrius they will provide transport services for you and we will get that important information to you using the HIway.

- Question (Karen Bell): I would be curious to know if we have that same list of use priorities today, and how do some of these users relate to that list of use cases.
    - Answer (Manu Tandon): In our December meeting we had done an end of year review and looked at the four most common use cases. However, this was when there were only 50 or so participants- we can bring that back to the next meeting with an update. It will likely be the same four uses, but we will update those slides for the next meeting and can do that every quarter.

Discussion Item 2: Advisory Group Update (Slides 9-13)

See slides 9-13 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Advisory group updates were presented by Micky Tripathi, CEO of the Massachusetts eHealth Collaborative (MAeHC).

The focus of the January workgroup discussions was around consent. As we know, Phase 1 is essentially secure email with a flexible approach for consent- the organizations needed to ask the patient for consent, with the option to say no, and the forms needed to name the Mass HIway. In Phase 2 there is a Relationship Listing Service (RLS) linking a patient with a particular clinical entity. There is no medical record information available- it is simply a listing of the patient and the organizations he or she has a consented relationship with.

(Slide 10) Advisory Group Update - A group of stakeholders, including privacy & security personnel from Beth Israel Deaconess, Tufts, Atrius, Holyoke Health, Hallmark Health, Partners Healthcare, Winchester, Baystate Health, the Pioneer Valley Information Exchange, and EOHHS, met to discuss how to operationalize consent- How do we best do this so it is clear to the patient, but also something that can be operationalized in a provider office? The group came up with a consensus view of how to look at the consent framework. The group agreed with a two part consent framework- One clear, concise consent form, accompanied with very standardized education material. The group went through a set of considerations- How much should the consent form contain? Everything the patient is consenting to? On on the other hand, if there is too much information, patients may not read the form. The group felt that the better way may be to have consent with supplemental standardized education materials- standard educational materials will reduce confusion as patients visit different offices.

- Question (Kristin Madison): Was the agreement a broad usage agreement, or was this something that would explain what it means to use the HIway?
    - Answer (Micky Tripathi): It would explain the push capabilities as well as the RLS capabilities. It depends a little bit on who the user is- some may not use the RLS, so there will need to be variations.
- Question (Kristin Madison): Will the consent be rich enough so that people understand what they are consenting to?

- Answer (Micky Tripathi): Sure, let me move to that slide.

(Slide 13) 2- Part Consent Approach - The idea here was to keep it simple, flexible and adaptable. The simple consent form will be recommended, but not required and education materials will be standardized. This way the consent form does not need to be updated any time there is a small change- the state can update the educational materials as needed. Adoptability was another concern- the large organizations in Boston may want their own consent form, while the small practice in Greenfield may not want create their own form.

- Question (Kristin Madison): Different authorized healthcare organizations and insurers may have concerns about the different uses. We do not want to have to recreate the form when there are new features, but if those features are important new features, the reason you may want them to re-sign is because it may change their answers. Issuing new educational material may not have the intended impact.
  - Answer (Micky Tripathi): The idea might be that if you updated the educational materials, you need to have the patient re-sign the consent form.
- Comment (Deborah Adair): A good example is last month when we were talking about the more complicated consent model with the three parts, I was thinking that if John Halamka has already collected thousands of forms, he would need to start from square one with the more complicated form. With this approach he would not. We do something similar with our genetic testing- we have the standard consent form and specific brochures that go along with that consent which get into more of the details. It would be very difficult to have a consent form contain all of the information.
- Comment (John Halamka): Our consent says we are going to be sharing your data with multiple parties, but after discussions with this group we feel we should add a line that says "here I opt-in for you to share that I have a relationship with Beth Israel Deaconess."
- Question (Karen Bell): I think this is acceptable as long as we stay in the realm of sharing for treatment purposes - other uses down the road may require more thinking. We may decide to work with other companies to gather data. The question I have is, would it be worthwhile to have some really big sharing categories on the original consent forms? I wonder if their might be some way to keep them comfortable at the level they are now, without creating confusion or concern.
  - Answer (Micky Tripathi): No clinical data is being held- no one can use it outside of the data holding entity. The HIway is agnostic and does not have visibility into what is being sent.
- Comment from Public (Lisa Fenichel): During the Consumer Advisory Group meeting I had pointed out that I think it is important to have something more proactive- there should be a way to confirm that the patient saw that education.

The feedback from the consent meeting was given to the Consumer Advisory Group. They suggested adding a "I need more information" check box. This is just an approach right now, but there are two considerations as we start to think through that. One, as we know, EHR systems are pretty bound right now, everything is binary - the box is either checked or not. So what would happen with "Need more

information" checkbox? There would be no way for the source system to capture that. The other is the idea of the transcription error - "needing more information" may be confusing for whoever is entering and storing the information. From a false positive perspective, if you check off no, you have recorded that the patient consented, even though they have not.

- Question from Public (Adrien Gropper): There is a public disclosure component to this, what is the process dealing with that? Will the patient have a way of knowing that they have agreed to have Beth Israel Deaconess use the Relationship Listing Service, but not Partners? Is that a legal issue?
    - Answer (Micky Tripathi): I cannot speak to the legality. Mechanically, with current systems they would need to go to the provider organization for identity proofing. The hope is that once the HIway matures and business processes mature, it will have a patient facing component so that the patient can look at their RLS entries. The issue is having the patient verify who they are.
- Comment (John Halamka): If you think about it, this gives us all latitude by taking processes we have defined for other purposes, for instance I have done a lot of work with the Department of Public Health and consent for sharing, and adapting them to align with the HIway. The thing I like is that you define meaningful consent. The last thing we want is to have each of us explain the HIway differently.
- Comment (Laurance Stuntz): This does not need to be used for Phase 2 only, it could be for Phase 1 as well. There are a lot of new organizations in the pipeline-they can give patients one consent to encompass both.
- Question (Karen Bell): Are other states doing this?
    - Answer (Micky Tripathi): Not that I am aware of, a lot of states are using a database approach which requires a lot more complex consent language. We act much more like a HISP. Originally when the program was designed, the idea was that the HISP should not have authorization due to the nature of their transactions, but we have Chapter 224 so we live in this weird middle world.

(Slide 10) Advisory Group Update Cont. - The Technology Advisory Group discussed participant addressing- a number of organizations are complex and would like to be able to create sub domains, like an e-mail address- as intuitive as possible. Turns out there is a standard and a spec out there- the plan is to stay in touch with national standards experts to make sure what we are doing is in line with the national standards. In some cases we are thinking ahead because we are further along than many other states.

There was also discussion around "Break the Seal" functionality. In Phase 2, with your permission, you are listed in the RLS and providers can only see an organization for which there is an established relationship, which usually means that the patient has been seen at that particular organization. What about the case where someone shows up in the Emergency Room of an organization they had never been to? In that circumstance, how would the providers get access? An organization can go into the RLS, search for a patient, see that they don't have access to view the patient's relationships, click a "break

the seal" dialogue box, and choose a reason for access from a drop down list. During the process a few things happen in the background- there will be a hard audit, and the organization itself will be notified that "someone in your organization has broken the seal." This way, the HIway will know and the organization will know and can audit that the HIway is being used as intended. The general consensus was to have these protections at a minimum.

- Comment (John Halamka): From a privacy perspective, we have this Magic Button with a number of organizations and in 1996 our Privacy Officer said "that's just horrible" because any participating affiliates can "fish" for records. Where today, it is required that the patient has been registered at both institutions- you can no longer fish. You could of course fraudulently register someone, but that again would be auditable. Overall it is a very nice safeguard.

The other thing that has come up in discussion was the idea that, similar to a credit monitoring program, a notification is sent to the patient anytime their Relationship Listing Service is updated. The patient can login to an e-mail system and do their own relationship audit.

- Comment (Kristin Madison): I think that is important, even if not everyone uses it- it's another element of confidence in the security.
- Comment (Micky Tripathi): The HIway has every intent of making this patient facing, right now it is a matter of business processes.
- Comment from Public (Adrien Gropper): I think it makes sense that the form the patient is asked to sign identify how they will be indexed into the RLS - I think the problem with doing that is the question of how reliable the matching is. At the very least, the consent has to have some way of identifying who the patient is, regardless of having to sign.
- Question (Kristin Madison): Was there discussion around best practices for telling the patient after the fact that they broke the seal?
    - Answer (Mark Belanger): We had discussed this in one of the work groups, there was a recommendation to ask the provider to inform the patient as a best practice.
- Comment (Deborah Adair): I think we just have to see how we end up doing this, even at Partners, if we have someone break the glass there is someone always watching. We could never manage telling every patient, but they can ask Partners at any time who has accessed the record.
- Comment (John Halamka): Maybe we can use a different term than "break the glass." In this case the patient has yet to give consent at that particular organization, but they have given consent for everywhere else that is listed.
- Question (Patricia Hunt): I thought you had to authorize on the event, but you were supposed to also authorize the people who are seeking the information?
    - Answer (Micky Tripathi): Those are really two separate issues and again we are still talking about an approach at this point. The idea is that the consent is about disclosing a record location. When I show up in the Emergency Room, that Emergency Room provider is going to be allowed to look at the Relationship Listing Service even though I never issued the consent for that institution. The patient has already given permission

for the other organizations to be listed, but they have not identified this particular organization.

- Comment (Kristin Madison): The concern would be around notification- yes I want this particular institution to access my information, but there needs to be a way afterwards to tell the patient.
- Comment (Micky Tripathi): Again, there is the back end auditing going on. The Emergency Room would get the notice that someone broke the seal at X time. Ultimately a patient will be able to see what happened. There are a number of business process gaps right now in the market.
- Question (Patricia Hunt): What is the next step, why would they need to just use the RLS?
    - Answer (Micky Tripathi): They would want to know where the patient has records- quickly identify where the patient was last seen and have the most accurate information.
- Question (Patricia Hunt): Even then this is incomplete- I do not know how this would adequately identify the patients, there are a lot of people with the same name. We have closed everything down with the Health Insurance Portability and Accountability Act (HIPAA), now we are opening everything up.
    - Answer (Micky Tripathi): I would reframe the question a bit- it does not open anything HIPAA related, it allows things to happen within the Act's parameters.
- Comment (Steven Fox): As a non-clinician, from a payer perspective, we are dealing with a lot of privacy concerns. It would be helpful to separate these situations by type of care. Do we really want these restrictions on the Emergency Department, versus the primary care physicians? Much like Accountable Care Organizations today, organizations get a notification their patient had been seen in the Emergency Room the previous day. We shouldn't lose the intent of what we are trying to do.
- Comment (Micky Tripathi): Just to clarify, it is only one dialogue box. The issue is how to operationalize it. We could have a list of authorized Emergency Room users and they would get seamless access, but the challenge of maintaining and synchronizing would be tough.
- Question (Meg Aranow): Would it be this process in the use of mass casualties, thinking along the lines of the Boston Marathon tragedy. It might be helpful if we are looking for different use cases for consumers.
    - Answer (Micky Tripathi): Good point- with Hurricane Katrina Surescripts enabled a whole bunch of access to information.
- Comment (John Halamka): When I first created a multi-institutional view of data, it was painfully detailed with HIPAA related questions about privacy - not sure if the internet is safe enough, what about two part Virtual Private Networks? All of this layered security which we thought was appropriate, but then when we started to use it we realized we could remove a lot of it- as comfort was gained we removed some restrictions. I have a feeling that we may be able to do something similar with this over time.
- Comment (Meg Aranow): When we implemented consent at Boston Medical Center we got comments from the Emergency Room and Urgent Care patients saying "I thought you already shared data with these people?"

- Comment (Deborah Adair): All of this should be in the patient education materials. Make it clear to the patient that they did not have a chance to sign on because they were in an emergency situation.
- Question from Public (Lisa Fenichel): Remind me- is it "Record Locator," or "Relationship Listing?"
    - Answer (Micky Tripathi): Good question, similar names with slightly different implications. For those that have been doing Health Information Exchange work, it is usually Record Location Service, but for these purposes we felt Relationship Listing was more appropriate- less negative insinuations.

(Slide 11) Advisory Group Update Cont. – The Legal and Policy Advisory Group went through a wide variety of issues [listed on slide] - there are a lot of things to still work out.

HIway Outreach & Sales Update (Slides 15-25)

See slides 15-25 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Mass HIway Update presented by Massachusetts eHealth Institute (MeHI) Health Information Exchange Director Sean Kennedy.

(Slide 15) Last Mile Program Transition - The Last Mile program has been working to get people connected to the HIway, increase adoption, and increase utilization to see Impact. As we think about shifting efforts, we are seeing the focus of The Massachusetts eHealth Institute move away from connection services to the adoption side of things. The HIway Operations team and EOHHS will continue getting organizations onto the HIway. We really want to ensure good customer service.

(Slide 16) Last Mile Program Transition Cont. - There is a pipeline of hundreds of organizations to transition over to EOHHS- some will continue as grantees which we will continue to support. The knowledge transfer is ongoing, making sure the processes and best practices are shared so that no one falls through the cracks.

(Slide 17)Last Mile Program Transition Cont. - It is clear that over the past year and a half we have built a good relationship with EOHHS. They clearly understand what participants need and there is strength in referral circles. We will jointly catalogue all of the different use cases- we want to continue to build out what grantees are seeing, what are we seeing in the market and build them out in a lot more detail.

We will continue to work on consumer education materials- this is something we are working on with EOHHS. There is already some draft content out there. We hope to develop more targeted education that get into some of the nuances of the HIway. We are working with the Council to identify weekly webinars and will look at some small workgroups. There is a Frequently Asked Questions library already in place which we will continue expanding.

(Slides 18-19) Progress by Region- This is something some of the grantees had asked for- asking who else is participating in my area. I have created, and will continue to update, a participant map, including the

stage/status of the connection process and use cases. In this example Milford Regional Medical Center will be using the HIway to send discharge summaries to Medway Country Manor and Care Tenders.

(Slide 20) Use Cases 'Transacting' on the HIway - We plan on having some of the use cases in a table on the website. Hopefully this will help organizations start to talk to one another and begin to collaborate. Organizations can use some of these use case resources as a starting point as they start to think about their particular use case.

(Slide 21) HIway Interface Grants- Progress - Last week was a tremendous week- big thanks to EOHHS. All of the grantees had to meet their Milestone 3 (testing with the HIway) by the end of January in order to receive payment - 11 out of the 13 grantees met that goal.

(Slide 22) HIway Implementation Grants- Progress – On the Provider side all but one got to their testing. There is a lot of interest and I think we will see a lot of activity next week. There is still a Project Officer on staff to work with them.

- Question from Public (Jacob Buckley – Fortin): Is there a trend in connection format for those provider grantees- webmail, Direct?
    - Answer (Sean Kennedy): It is really a mix.

(Slide 23) The Rally...a HIway Transact-a-thon - This was our way to show The Office of The National Coordinator for Health Information Technology support-thank them for the grant funding. This is a way to build awareness and interest, as well as showcase success stories.

(Slide 24) *The Rally...a HIway Transact-a-thon Cont.* - A list of participants was provided- The Office of The National Coordinator for Health Information Technology is going to participate. We encourage the Council to sign up or send a tweet.

(Slide 25) The Rally...a HIway Transact-a-thon Cont. – MeHI attended the ONC Health Information Technology conference. We added a Quick Response Code to the bottom of our sign to quickly get people to the registration page for the event. We were the only attendees that had anything on our sign and had 40 hits- pretty happy with the activity. Remember, this is not just for organizations connected to the HIway, it's also about being able to put your handle out there and support the efforts of others.

Discussion Item 4: Wrap-Up (Slide 27)

See slide 27 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Wrap-up presented by Darrel Harmer, Assistant Chief Information Officer of the Health Information Exchange, EOHHS

The schedule for the 2014 HIT Council Meetings was provided.

- ~~January 13~~
- ~~February 3~~
- March 3

- April 7
- May 5
- June 9
- July 7
- August 4
- September 8
- October 6
- November 3
- December 8

** All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21th floor, in the Matta Conference Room.*

The Next HIT Council Meeting is scheduled for **March 3, 2014** from 3:30pm-5pm at One Ashburton Place, 21th floor, in the Matta Conference Room.

The HIT Council meeting was adjourned at 4:58 P.M.